health insurance. Under the Senate HELP Committee bill, that number is much higher. It is 34 million who would still not be covered. But there is an assumption there, although it wasn't included in the bill, that Medicaid would be expanded. That would cover more people. So that number may be overstated. But the Senate Finance Committee assumes 25 million people will be without health insurance.

So you will have higher taxes, a tremendous amount of higher spending—up to about $2 trillion under any of these bills—and an expansion of government here in Washington, DC, cuts to Medicare reimbursements—to seniors—across this country, and all for what? Higher premiums for most Americans, for people who currently have insurance, to hopefully cover some Americans. When you are spending $2 trillion, there ought to be some advantage to that, but clearly a lot of Americans are still going to be without health insurance when this is all said and done.

I am concerned. I think a lot of our colleagues here in the Senate—and not just on our side of the aisle, but I think a number on the other side too—have expressed concerns about starting the debate a quarter of a trillion dollars in the hole by putting a bill on the floor that is going to spend a quarter of a trillion dollars—$250 billion—over the next 10 years that is not paid for. That puts any bill that is considered later completely out of balance, and it is a gimmick that is designed to allow the President and the Democratic majority to say our health care reform bill is deficit neutral. Well, sure, if you take the $250 billion and back it out, it is easy to say it is deficit neutral, when in fact now it is going to be $200 billion. They have about an $80 billion overage on the bill in the Finance Committee, but it is still going to be $200 billion out of balance when you do this, again, to be financed with more debt and more borrowing, which is exactly what I think we want to avoid, and particularly when you are running deficits as far the eye can see.

This last year, about 43 cents out of every dollar that was spent here at the Federal level—in Washington, DC—was borrowed. There isn't anyplace in America where you can function like that and still be in business. If you are a person doing that in your personal household finances, you would be forced into bankruptcy. If you were a small business, you would be forced into bankruptcy. Frankly, were it not for the fact that other countries around the world are financing America's debt, we would be in bankruptcy. Because you can't borrow 43 cents of everything you spend, as we are doing here in Washington, DC. In fact, to put it in perspective—and a lot of Americans understand this—if you are a family with an annual income of $62,000, it would be the equivalent of spending $108,000. That is what we are doing here in Washington, DC. Of all the money we spend in a given year, 43 percent of that is borrowed. We cannot continue to sustain that.

I hope that before this bill comes to the floor, we can reach an agreement about amendments that might be offered. I would say our side, the Republican side, has amendments it would like to offer to this bill that would help pay for it, help reduce the amount or perhaps entirely reduce the amount that would be borrowed in order to finance the physician reimbursement fix, on which we all agree. As I said, there is not anybody on this side who does not agree that needs to be done. In fact, Senator CORNYN offered an amendment to the bill that would provide a 2-year fix, a 2-year solution to the problem for physician reimbursement. It was voted down. It was defeated, that amendment, in the Senate Finance Committee.

We are looking. We are proactive. We have to address this issue. This issue was created by the Balanced Budget Act back in 1987. I was a Member of the House of Representatives at the time. I voted for that balanced budget agreement, but it included what was called a sustainable growth rate formula by which physicians are reimbursed. As I said earlier, in January of this year, based upon that formula, physicians would receive a 21.5-percent reduction in their fees, in their reimbursements.

Everybody here—I should not say everybody. I can't speak for everybody. But I think most Senators on both sides of the aisle acknowledge that issue has to be addressed. We need to fix that, but we have to do it in a way that is fiscally responsible. We want an opportunity to offer amendments that would allow us to do that.

As of last week, that request was being rejected. There was going to be a cloture vote today, which I understand now has been vitiated, which means perhaps the leaders are working together on an agreement that would allow Senators on both sides to offer amendments to this legislation that would help pay for it.

I think it is telling that there are Democrats who are uncomfortable with the idea of adding $¼ trillion to the Federal debt with the very first vote we will cast on health care in the Senate Chamber.

I hope we can reach an agreement. I hope the leaders will be able to do that and this will be an open process, that we debate, and there will not be any mad rush to try to cut off debate. Rather, Senators on our side would have an opportunity to fix the issue that is going to put a lot of physicians in a very uncomfortable position if we do not address it but do it in a way that also is fair to the American taxpayer and make sure we, as a nation, are honoring the responsibility we have, not just to fix this issue for today but to provide a better and brighter and more secure future for future generations of Americans. It is a future which, I would add, is very much in jeopardy and in peril if we continue to spend and borrow and tax at the rate that is contemplated in the health care reform bill but, more important, with the very first vote on that health care proposal, which is to add $250 billion to the Federal debt.

I yield the floor.

I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. CASEY. I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. CASEY. Mr. President, I rise to talk about health care in three ways, three different subjects but all vitally important to making sure we get the job done in the next couple weeks. As many Americans know, in the Senate right now, we have the HELP Committee bill that passed in July and the recent passage of the Finance Committee bill coming together in a merger process which is days away from completion or certainly in the near future. As that process unfolds, there are parts of our bill, meaning the HELP Committee bill, that I hope remain intact or at least, in large measure, are left as part of the final Senate bill.

One part is on the issue of children's health insurance. We had an important debate about this program, which was authorized in 2009, so that within the next several years, within the next 4 years, maybe by the end of 4 years, we will have as many as 14 million children across America covered by that program, a tremendous advancement from where we were even 10 years ago. It has shown results in a lot of places. It is a well-tested program.

One of the more recent debates, within the Finance Committee, was whether children in CHIP, whether that program itself would be stand-alone—as I believe and as I am glad the Finance Committee agreed with me and with others—or whether it would be folded into the exchange. They didn't do that in the Finance Committee. I am glad they did not.

In this instance, we have a program which started in States such as Pennsylvania back in the early 1990s and then became a national program in the mid-1990s, about 1997. What we have seen in Pennsylvania are tremendous results. I ask unanimous consent to have printed in the RECORD a one-page survey by the Pennsylvania Insurance Department from 2008 about uninsured numbers, ages zero to 18 and then 19 to 64.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Estimated Number of Pennsylvania Children and Adults Who Lack Health Insurance by County [1]

	Age 0 to 18				Age 19 to 64			
County	Uninsured	Insured	Total	% Uninsured	Uninsured	Insured	Total	% Uninsured
Adams	2,331	21,766	24,097	10%	9,558	53,515	63,073	15%
Allegheny	5,883	274,523	280,406	2%	69,529	665,405	734,934	9%
Armstrong	1,590	13,415	15,005	11%	4,330	38,093	42,423	10%
Beaver	2,143	36,695	38,838	6%	12,914	92,130	105,044	12%
Bedford	1,771	9,336	11,107	16%	6,047	24,200	30,247	20%
Berks	3,770	96,735	100,505	4%	27,803	216,690	244,493	11%
Blair	572	28,417	28,989	2%	8,212	67,702	75,914	11%
Bradford	983	14,062	15,045	7%	4,740	32,474	37,214	13%
Bucks	4,575	147,546	152,121	3%	34,950	353,694	388,644	9%
Butler	898	43,541	44,439	2%	9,864	102,590	112,454	9%
Cambria	276	31,312	31,588	1%	11,095	76,889	87,984	13%
Cameron	45	1,168	1,213	4%	372	2,845	3,217	12%
Carbon	462	12,681	13,143	4%	5,534	33,222	38,756	14%
Centre	344	31,119	31,463	1%	11,730	82,134	93,864	12%
Chester	1,440	122,984	124,424	1%	24,300	275,731	300,031	8%
Clarion	544	8,518	9,062	6%	3,777	20,901	24,678	15%
Clearfield	759	16,863	17,622	4%	7,502	42,994	50,496	15%
Clinton	160	8,490	8,650	2%	2,538	19,831	22,369	11%
Columbia	1,036	13,555	14,591	7%	5,966	34,076	40,042	15%
Crawford	616	21,033	21,649	3%	8,190	45,437	53,627	15%
Cumberland	4,188	46,941	51,129	8%	16,021	124,999	141,020	11%
Dauphin	3,882	58,147	62,029	6%	14,038	143,028	157,066	9%
Delaware	9,362	136,524	145,886	6%	36,927	294,072	330,999	11%
Elk [2]	440	7,340	7,340	6%	1,371	18,590	19,961	7%
Erie	1,539	68,984	70,523	2%	16,250	153,179	169,429	10%
Fayette	1,569	30,051	31,620	5%	15,348	73,428	88,776	17%
Forest	42	1,137	1,179	4%	649	3,567	4,216	15%
Franklin	2,225	30,731	32,956	7%	13,814	70,357	84,171	16%
Fulton	134	3,272	3,406	4%	1,131	7,899	9,030	13%
Greene	333	8,393	8,726	4%	3,667	22,128	25,795	14%
Huntingdon	642	9,118	9,760	7%	4,043	24,908	28,951	14%
Indiana	1,261	18,459	19,720	6%	6,284	48,583	54,867	11%
Jefferson	814	9,387	10,201	8%	4,031	23,322	27,353	15%
Juniata	219	5,438	5,657	4%	1,785	12,239	14,024	13%
Lackawanna	3,267	43,955	47,222	7%	19,025	105,589	124,614	15%
Lancaster	16,301	114,518	130,819	12%	25,582	267,379	292,961	9%
Lawrence	1,011	19,973	20,984	5%	7,713	46,223	53,936	14%
Lebanon	1,290	28,407	29,697	4%	8,554	67,877	76,431	11%
Lehigh	2,745	79,598	82,343	3%	28,697	174,562	203,259	14%
Luzerne	2,129	65,441	67,570	3%	14,100	174,269	188,369	7%
Lycoming	1,402	25,987	27,389	5%	9,719	61,528	71,247	14%
McKean	453	9,696	10,149	4%	5,250	21,313	26,563	20%
Mercer	1,205	26,519	27,724	4%	10,083	59,853	69,936	14%
Mifflin	542	10,402	10,944	5%	3,116	23,793	26,909	12%
Monroe	795	40,919	41,714	2%	16,895	88,087	104,982	16%
Montgomery	7,379	182,900	190,279	4%	34,577	437,010	471,587	7%
Montour	106	4,114	4,220	3%	1,106	9,385	10,491	11%
Northampton	890	67,579	68,469	1%	19,189	161,434	180,623	11%
Northumberland	411	18,772	19,183	2%	5,548	49,900	55,448	10%
Perry	971	9,785	10,756	9%	4,030	24,681	28,711	14%
Philadelphia	26,012	373,302	399,314	7%	131,608	728,700	860,308	15%
Pike	1,386	11,986	13,372	10%	6,267	30,232	36,499	17%
Potter	191	4,096	4,287	4%	1,779	8,474	10,253	17%
Schuylkill	197	29,556	29,753	1%	9,371	81,244	90,615	10%
Snyder	699	8,697	9,396	7%	2,181	21,297	23,478	9%
Somerset	688	15,474	16,162	4%	6,613	41,350	47,963	14%
Sullivan	46	1,300	1,346	3%	482	2,992	3,474	14%
Susquehanna	982	8,730	9,712	10%	4,278	21,287	25,565	17%
Tioga	898	8,563	9,461	9%	3,159	21,517	24,676	13%
Union	1,264	7,975	9,239	14%	6,601	21,497	28,098	23%
Venango	629	12,068	12,697	5%	5,038	28,339	33,377	15%
Warren	321	8,978	9,299	3%	2,963	22,172	25,135	12%
Washington	1,416	43,772	45,188	3%	17,036	108,985	126,021	14%
Wayne	301	10,758	11,059	3%	5,271	25,529	30,800	17%
Westmoreland	1,827	75,593	77,420	2%	21,682	201,168	222,850	10%
Wyoming	230	6,522	6,752	3%	1,889	15,452	17,341	11%
York	4,166	94,872	99,038	4%	34,215	226,913	261,128	13%
Total	138,558	2,858,488	2,997,046	5%	877,927	6,680,883	7,558,810	12%

1. Figures derived from the 2008 Health Insurance Survey conducted by Market Decisions LLC for the Pennsylvania Insurance Department (PID). All numbers and percentages are estimates and have margins of error that must be considered in any assessments or comparisons. (See the section on survey methodology in the survey, available on the PID Web site). This chart does not reflect what portion of the uninsured may be eligible or may qualify for CHIP, adultBasic, Medicaid, or any other government program. 2. Due to the small number of uninsured children found in the sample in Elk county, the number was estimated based on the results in adjacent counties.

Mr. CASEY. What this chart shows is when we compare individuals who happen to be zero to 18 in age versus 19 to 64, we find that in Pennsylvania, across the 67 counties, we have an uninsured rate of 5 percent among children. So ages zero to 18, it is 5 percent uninsured. It is still too high—we want to bring that down to zero—but much lower than it had been. But among the age category 19 to 64, meaning everyone above the age of 18 prior to the time they have an opportunity to receive Medicare, 12 percent are uninsured in Pennsylvania. I doubt that is much different across the country.

One of the lessons from that is that when we take concerted action to focus, whether it is public resources or private resources but of a strategy for health care, we can bring the numbers down dramatically. So children's health insurance in Pennsylvania is in much better shape than it was 10 or 15 and certainly 20 or 25 years ago. But we haven't, as a country, begun to focus on that age category 19 to 64. If it is 12 percent in Pennsylvania, it is probably similar across the country because there has been no strategy for people in that age category comprising our workforce.

We have to bear that in mind. When we have one category with an uninsured rate of 5 percent versus another that is more than double that at 12 percent, we have to continue to focus strategies in the debate on that age category. In this process of coming to a bill, I believe there are several policies and several strategies that will get us to the point where the rate for ages 19 to 64 will come down as well. As many Americans know, the Affordable Health Choices Act, the bill from the HELP Committee, has as its goal and is premised upon the idea of covering as many as 97 percent of the American people. We finally have a strategy for every age group in addition to what we have tried to do for children and what we have done to help older citizens, over more than 40 years now, over the age of 65 or 65 and up.

One of the parts of the HELP Committee bill which does not get a lot of attention is a part of the bill which is set forth in sections 3201 to 3210. It starts on about page 228 of the HELP Committee bill. I know these bills are big, well more than 800 pages, but this section on the Community Living Assistance Services and Supports Act, the so-called CLASS Act, is a breakthrough—I think to be understated—because what it does is provide individual Americans who have functional limitations to be able to continue working but also to provide some of the help that goes into providing them the wherewithal to continue working.

Here is what the fundamental purpose is. I am reading from the summary: The fundamental purpose of the bill ''is to establish a national voluntary''—voluntary—''insurance program for purchasing community living assistance services and supports in order to provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence''—probably the most important word in that paragraph—''and live in the community through a new financing strategy for community living assistance services and supports,'' and ''establish[ing] an infrastructure that will help address the Nation's community living assistance services and supports needs, and alleviate burdens on family caregivers.''

What we have now, unfortunately, in many places is two or three major problems. The individuals themselves are not able to work sometimes; they have an inability to work because of limitations, and they are not able to pay for the kind of care they need. That is the main problem.

The second problem is, in many families, caregivers try to make up for that. If the family member with limitations cannot pay for services, family members provide the kind of services they would hope to get from some other person or entity.

What we are doing here is relieving a burden on individuals so they can be fully functional and independent because of the support and help they get, such as someone coming into their home in the morning to help them get off to work and to be able to meet them at the end of the day and help them with so-called activities of family living, things we all take for granted in our daily lives: everything from feeding and bathing and other fundamental things that all of us have to do every day. With a little bit of help from someone, many Americans can lead a life of employment, a life of dignity, and a life of contribution to our economy.

It also gives some real help to family members. So we will talk more about the details of how this works. I should mention the person who was the driving force on this legislation—and he and his staff worked on this for years—was the late Senator Kennedy. He spent many years developing this program, developing the CLASS Act, and making sure it was part of our bill. That is why we wanted to make sure it was part of the Affordable Health Choices Act, and it should be part of the final health care legislation we enact here in the Senate. If we are going to do the right thing, it will be in the bill. I think most people here want to do the right thing as it relates to people with functional limitations who can contribute more to their workplace and contribute more to our economy.

Senator Kennedy's work was focused not just on providing a program to give people that opportunity, his focus was also: How can we do it in a way that is fiscally responsible? Well, this program provides not just a lot of help for people with limitations and their families, but it also does not cost the Federal Government in the process because people will be paying in overtime and then have the opportunity to use those resources when they need them.

Let me finally move to another area in the remaining time I have. In addition to the importance of preserving the Children's Health Insurance Program the way it is right now—which I think was a great advancement in the Finance Committee—in addition to enacting legislation which will have the CLASS Act as part of it, the third thing I am going to mention today is an issue that has received a lot of attention, but sometimes we do not highlight some of the elements that are very important to the American people. I speak of the so-called public option, which in our Senate health care bill, the HELP Committee bill, is entitled the ''Community Health Insurance Option.''

One of the most important parts of the bill—in fact, I think the first word in the section is the word ''voluntary.'' When I was going across Pennsylvania talking to people about our health care bill—and our bill passed in July, so when I was on the road in August, we had a chance to talk about a bill, not just a concept but a bill we had already passed out of committee—some people who were opposed to the public option would ask a question or make a statement, and often they would say to me: Well, I don't want to be forced into some government program and lose my ability to choose or lose some of the rights I have now.

I would point to the Community Health Insurance Option section of the bill and say: The first word is ''voluntary.'' There is no requirement here. I think that mythology kind of got ahead of the truth. It is voluntary; that is, voluntary as it relates to an individual but also voluntary as it relates to a provider.

Second, as to the benefit package, as we wrote it in our bill, in the HELP Committee, it would meet the so-called gateway. In our bill we call it a ''gateway.'' In the other bills, they call it an ''exchange.'' But it meets the gateway standard by offering coverage that has an essential benefit package, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, preventive and wellness services, and pediatric services. States can offer additional benefits beyond that essential benefit package with any cost of such additional benefits being assumed by the State. So that is what the public option in our bill, the Community Health Insurance Option, would offer as a benefit package.

The premium rates will be set by the Secretary of Health and Human Services at an amount sufficient to cover expected local costs—local costs. So you are going to have a lot of impact and relevance as to what is happening in the local community. And also—this is very important—the Community Health Insurance Option has to meet

solvency standards. It cannot just operate and not worry about standards that involve solvency. If there are States that have higher levels or higher requirements as to solvency, the public option would have to meet that.

The reimbursement rates will be negotiated by the Secretary and shall not be higher than the average of all local—local—gateway reimbursement rates.

I mentioned the importance of solvency as a requirement.

Startup funds will be provided by the Treasury to cover costs of initial operations and cover payments for the first 90 days of the plan's operation. But then that public entity, which is State based, would have to pay the money back over time. I think that is critically important to point out.

Finally, State-based advisory councils will provide recommendations to the Secretary on operations and policies regarding the Community Health Insurance Option, to take advantage of local innovative efforts and meet local concerns. So this is not some entity that is going to operate in Washington. It is an entity that will have not just public input and local input and local relevance but actually will take advantage of local innovative efforts that we see all across the country. I know in Pennsylvania there are hospitals or hospital systems or communities that do things a different way and are very successful, and we have to be giving them the opportunity to have that kind of flexibility.

I believe it is the right thing to do to have as part of the final bill a public option. I believe our bill we passed out of committee is the right way to do it. Others might have another version of it. But I believe the Community Health Insurance Option is a voluntary, focused way to make sure we are injecting real competition and thereby lowering costs but also enhancing choice.

One thing we do not want to do at the end of this road is limit choices people have. A lot of people will stay with their private insurance policy or their private plan. They will want to stay there. But others may say: I am in such a predicament or I am in such a cost situation that I need to choose a public option.

Finally, Mr. President—I will wrap up with this—I believe this debate has been critically important to the American people, even the debates that get a little heated. It is very important we get this right. It is very important we have spent the time we have spent over these many weeks and months. But we are reaching the point now where we are down to weeks, thank goodness, not months.

I believe we can get this right, we can put in place strategies to give people peace of mind, so when they go to work in the morning, they do not have to worry, as they do, about health care—the cost of it, the burden of it, being denied coverage because of a preexisting condition or having a child denied coverage because of that or a loved one. I believe we can also begin to wrestle the costs to the ground and not have them spiraling upward, as they have been doing for 10 or 15 or more years. I also believe we can enhance choice and quality.

Even with all the debates we are having, all the disagreements we sometimes have here in Washington, there is a lot of consensus about the need to pass a bill, about the need to enhance prevention efforts and quality efforts. I believe we can get there. But we will continue to highlight some major aspects of the bill, and we are going to continue to fight hard for these fundamental priorities of health insurance reform.

Mr. President, with that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, how much time is remaining on the Republican side?

The ACTING PRESIDENT pro tempore. There is no divided time at this point. Morning business goes until 4:30 p.m.

Mr. ALEXANDER. Mr. President, I ask unanimous consent to speak in morning business.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, after a lot of serious debate and discussion, we apparently are about to come to the point where we have our first vote on health care reform.

What is it the Democrats—those on the other side—propose we do? Add one-quarter of a trillion dollars to the national debt. I thought this debate was supposed to be about reducing costs—reducing costs to the government and reducing costs to individuals across this country who cannot afford to pay for health care insurance. And then, as we find ways to reduce the costs of what we are doing, we can begin to expand health care coverage to the Americans who do not have insurance. But it is as big a problem—or bigger—today that those who do have health care insurance—and that is about 250 million of us out of 300 million—that many Americans cannot afford their health care.

So our focus is, I thought, on cost. How do we reduce costs to the government and costs to the American people? What we see is that the very first vote on health care reform will be on a proposal to increase the debt by $247 billion over 10 years in order to pay for Medicare doctors reimbursements. This is not the insurance companies talking. This is not the Republicans talking. This is not one news commentator talking. This is the proposal by the Democratic side, that the first vote will be to increase the debt by a quarter of a trillion dollars.

I wish to talk for a few minutes about this bill as we see it. Here we are supposed to be having legislation to reduce the costs to the government, and we apparently are going to, as the first step in the wrong direction, add a quarter of a trillion dollars to the government. The second thing we are trying to do is to reduce your costs—the costs that each of us pays for our health care insurance. The outlines of the bill we see coming through the Congress would actually increase premiums.

I would ask the American people and ask my colleagues: If our goal is to reduce costs—and we are adding to the debt and increasing premiums instead of reducing premiums and reducing the debt—why are we doing this?

Let me start first with adding a quarter of a trillion dollars to the debt. Here is what the proposal would be. You will remember a few days ago there was a great deal of congratulations when the Finance Committee finished a lot of hard work, and they said: This is a deficit-neutral bill. It doesn't add anything to the debt. That is what the Congressional Budget Office said based on a series of assumptions. That is something to be proud of because the President himself has said he won't sign a piece of legislation that adds one dime to the debt, and then he added to that, ''and I mean it,'' like a parent who wanted to make sure he was being heard by unruly Members of Congress.

I am glad he said that. I heard him say it earlier in the year when he had a summit on the condition of the Federal budget. Democrats and Republicans—we all went down to the White House. People came in and said: If we don't do something about the increasing debt in our country, our children and grandchildren aren't going to have a country. That was not overstating it. Everyone at the President's summit agreed that the principal cause of runaway debt in America is health care. It is Medicare and Medicaid.

Just these past few days—here is the weekend newspaper in Tennessee. This is the Nashville Tennessean on Saturday: ''Deficit leaps to $1.4 trillion.'' I think most Americans—I know at least most Tennesseans—are deeply concerned about this. But lest you think a Republican Senator is exaggerating the problem, let me just read a few paragraphs from the Associated Press story:

Deficit leaps to $1.4 trillion. Economists warn of crisis if U.S. fails to act.

This is an Associated Press story.

What is $1.42 trillion? It's the federal budget deficit for 2009, more than three times the most red ink ever amassed in a single year.

It's more than the total national debt for the first 200 years of the Republic, more than the entire economy of India, almost as much as Canada's, and more than $4,700 for every man, woman and child in the United States.

Yet the first proposal, the first vote on health care is going to be to add to that debt.

The Associated Press article continues: